Island
MEDICAL CARE, PLLC

Medical Record Release Form

I, _____ authorize that my ***complete medical record*** be released:

From the Current/Previous Provider(s):

Name:_____

_____

Address:_____

City:_____ State:_____ Zip: _____

To the New Provider: **Akbar A. Khan, MD (Island Medical Care, PLLC)**

Address: _____

City: _____ State:_____ Zip:_____

Fax: 718 – 475 - 9398

Patient's: Name: _____ D.O.B.:_____

Address:_____

City:_____ State:_____ Zip: _____

Signature: _____